

5616

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARLOTTE HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phys Mem. Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Marie BARBER</u>		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-58</u>
9. AGE (In years last birthday) yrs. <u>12</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES ELWOOD BARBER</u>		14. MOTHER'S MAIDEN NAME <u>ALICE LUCILLE BUTLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO <u>prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>14 hrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>5-13-58</u> , 19 <u>58</u> , to <u>5-13-58</u> , that I last saw the deceased alive on <u>5-13-58</u> , 19 <u>58</u> , and that death occurred at <u>2:00</u> P. M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Tr Johnson</u> M.D.	ADDRESS (Street, city or town, state) <u>Laplatas Md.</u> DATE SIGNED <u>5-13-58</u>
PHYSICIAN'S NAME (Type)	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Bryantown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 15 58</u>	24b. REGISTRAR'S SIGNATURE <u>Quinn</u>

4000194 XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1885		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 25 1932		10:15 AM		10		15		00	
PLACE OF INTERMENT		NAME OF CEMETERY		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF FUNERAL HOME	
CATHOLIC CHURCH		ST. MARY'S CEMETERY		FATHER J. J. HARRIS		FATHER J. J. HARRIS		JAMES H. HARRIS	
DATE OF INTERMENT		TIME OF INTERMENT		HOUR OF INTERMENT		MINUTE OF INTERMENT		SECOND OF INTERMENT	
JAN 26 1932		10:30 AM		10		30		00	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF NURSE		NAME OF MIDWIFE		NAME OF DENTIST	
DR. J. J. HARRIS		DR. J. J. HARRIS		DR. J. J. HARRIS		DR. J. J. HARRIS		DR. J. J. HARRIS	
NAME OF CORONER		NAME OF JURY		NAME OF JURY		NAME OF JURY		NAME OF JURY	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS. IT IS NOT VALID FOR ANY OTHER PURPOSES.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05608

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomon Key</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Franklin</u> Last <u>BRAWNER</u>		4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13 1913</u> 45 yrs.
9. AGE (in years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Robert Clinton Browner</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Toye</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-18-8323</u>		17. INFORMANT <u>Robert C. Browner, Indian Head, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5-15-58</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		DATE SIGNED <u>5-15-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Charles</u>		22d. LOCATION (City, town, or county) (State) <u>Glymont, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-10-10

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF RESULTS

DATE  
PLACE HERE



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page]*

RECEIVED



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 6.9 Film 0229 6-3-58 et

CERTIFICATE OF DEATH

05609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wayside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wayside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>HATTIE BEBECCA BROWN</u>		4. DATE OF DEATH <u>May 19 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bowel Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eleanor Rosewell</u>		Address <u>Baltimore Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Terminal</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>1 year</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-15-58</u> , 19 <u>58</u> , to <u>5-18-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-15-58</u> , 19 <u>58</u> , and that death occurred at <u>12:30 A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J B Detton</u>		ADDRESS (Street, city or town, state) <u>La Plata, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>V.B. DETTOR</u>		DATE SIGNED <u>5/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shilo M.E.</u>		22d. LOCATION (City, town, or county) (State) <u>Wayside Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. LaPlata</u>		ADDRESS <u>LaPlata, Maryland</u>	
24a. REC'D BY REGISTRAR <u>May 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
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82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rome</u>		c. LENGTH OF STAY IN TB <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Issue</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE WILLIAM CAMPBELL</u>				4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alec CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>DENNIE CAMPBELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Name <u>IRBERTHA CAMPBELL</u> Address <u>Issue MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vas. Accident</u> 331X DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5-8-58</u> <u>1954</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E J EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E J EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		22d. LOCATION (City, town, or county) (State) <u>Issue, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Quickenich</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MA 02111

Page Two of Two

1. Name of Deceased: [Illegible]

2. Date of Death: [Illegible]

3. Place of Death: [Illegible]

4. Cause of Death: [Illegible]

5. Manner of Death: [Illegible]

6. Signature of Medical Examiner: [Illegible]

7. Date of Signature: [Illegible]

8. Signature of Coroner: [Illegible]

9. Date of Signature: [Illegible]

10. Signature of Registrar: [Illegible]

11. Date of Signature: [Illegible]

12. Signature of [Illegible]: [Illegible]

13. Date of Signature: [Illegible]

14. Signature of [Illegible]: [Illegible]

15. Date of Signature: [Illegible]

16. Signature of [Illegible]: [Illegible]

17. Date of Signature: [Illegible]

18. Signature of [Illegible]: [Illegible]

19. Date of Signature: [Illegible]

20. Signature of [Illegible]: [Illegible]

21. Date of Signature: [Illegible]

22. Signature of [Illegible]: [Illegible]

23. Date of Signature: [Illegible]

24. Signature of [Illegible]: [Illegible]

25. Date of Signature: [Illegible]

26. Signature of [Illegible]: [Illegible]

27. Date of Signature: [Illegible]

28. Signature of [Illegible]: [Illegible]

29. Date of Signature: [Illegible]

30. Signature of [Illegible]: [Illegible]

31. Date of Signature: [Illegible]

32. Signature of [Illegible]: [Illegible]

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70. Signature of [Illegible]: [Illegible]

71. Date of Signature: [Illegible]

72. Signature of [Illegible]: [Illegible]

73. Date of Signature: [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 229 6-1-58 et

5620

## CERTIFICATE OF DEATH

05611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Waldorf</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Waldorf</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RR-1 - Waldorf Md</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SIMON</u> Middle <u>EPP</u> Last <u>EPP</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 3, 1863</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Daniel Epp</u>		14. MOTHER'S MAIDEN NAME <u>Amelia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Son - Leonard Epp - Waldorf Md</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho Pneumonia</u> <u>491X</u> DUE TO <u>Upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>Weakness Secondary to operation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 days</u> <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Intestinal Surgery - 4/24/58</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>				21. I certify that I attended the deceased from <u>Apr 28, 1958</u> , to <u>May 26, 1958</u> , that I last saw the deceased alive on <u>May 26, 1958</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vahel M. Seron</u> M.D. <u>Agassaw Md</u>				ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>5/26/58</u>			
PHYSICIAN'S NAME (Type) <u>VAHEL M. SERON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u> ADDRESS <u>  </u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUN 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05612

Reg. Dist. No.

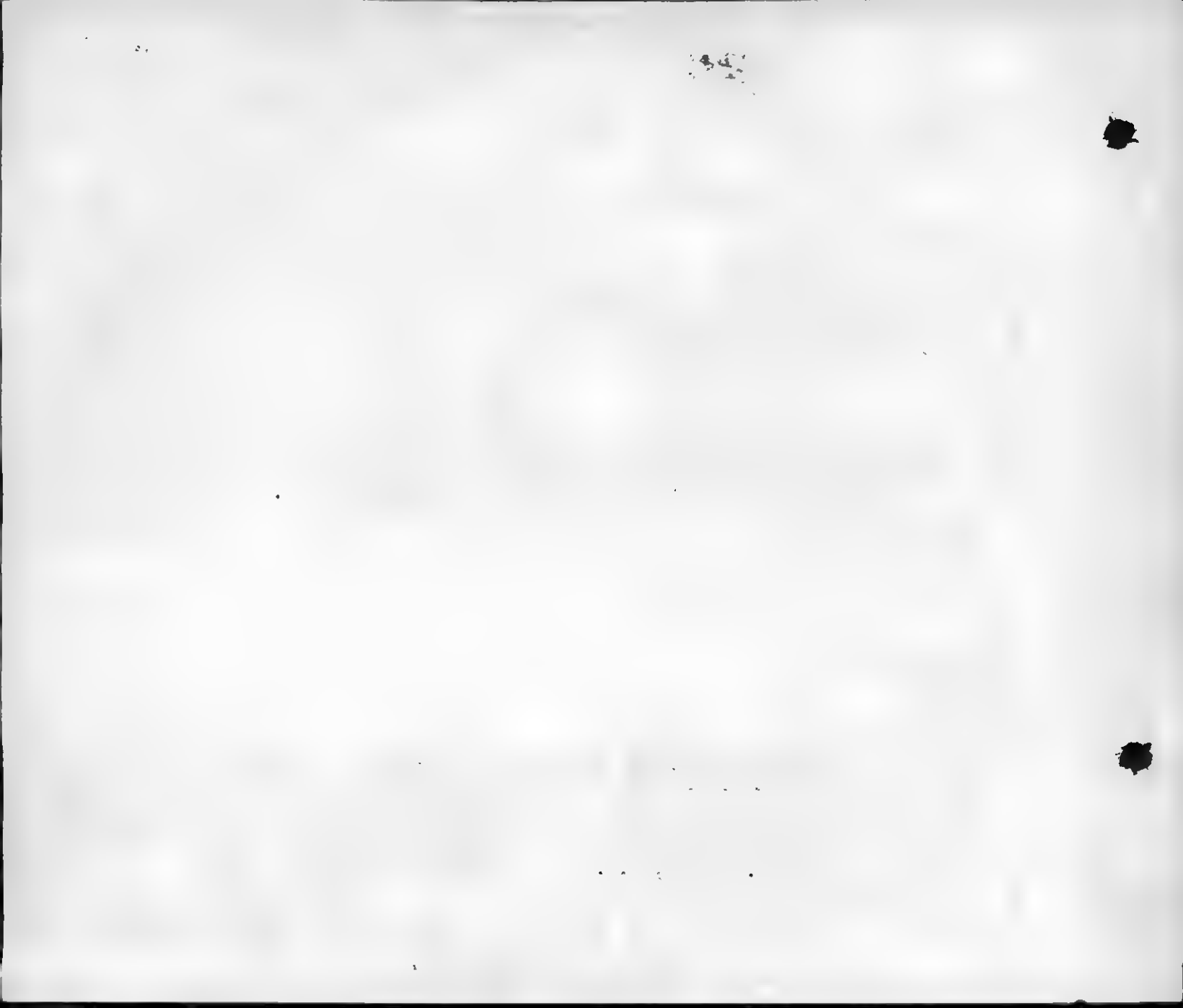
FOR STATE  
HEALTH DEPT.

5621

Item 9 Filed 228 5-15-58 et

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Durham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS 1210 Glenn Street	
3. NAME OF DECEASED (Type or print) First HARRY Middle Thomas Last FIELDS		4. DATE OF DEATH Month May Day 6 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY W.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ora Downing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT James Mayo Laurel Reid		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature] M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/7/58	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Buried	22b. DATE THEREOF 5/7/58	22c. NAME OF CEMETERY OR CREMATORY Beachwood	22d. LOCATION (City, town, or county) Durham N.C.
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		24a. REG'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE [Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5622 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Loplat</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Lakaeco md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>GORMAN</i> Middle <i>Lee</i> Last <i>HIGGS</i>		4. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7, 1908</i>
9. AGE (In years last birthday) <i>50</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Forming</i>	
11. BIRTHPLACE (State or foreign country) <i>Stromy co</i>		12. CITIZEN OF WHAT COUNTRY? <i>md</i>	
13. FATHER'S NAME <i>Herbert Higgs</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Anna Rice</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>217-38-280</i>	
17. INFORMANT <i>Jacob Bowling Waldborf md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac dilatation</i> <i>104.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Failure</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. 3 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Apr</i> , 19 <i>55</i> , to <i>May 13</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 9</i> , 19 <i>58</i> , and that death occurred at <i>9:30 p.m.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>J. J. Johnson</i>		ADDRESS (Street, city or town, state) <i>Loplat, md</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Johnson</i>		DATE SIGNED <i>13 May 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-16-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>	22d. LOCATION (City, town, or county) (State) <i>Charles md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Mc</i>		ADDRESS <i>Loplat md</i>	
24a. REC'D BY REGISTRAR <i>W. J. Smith</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>	
DATE <i>MAY 20 '58</i>			

1

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5623

## CERTIFICATE OF DEATH

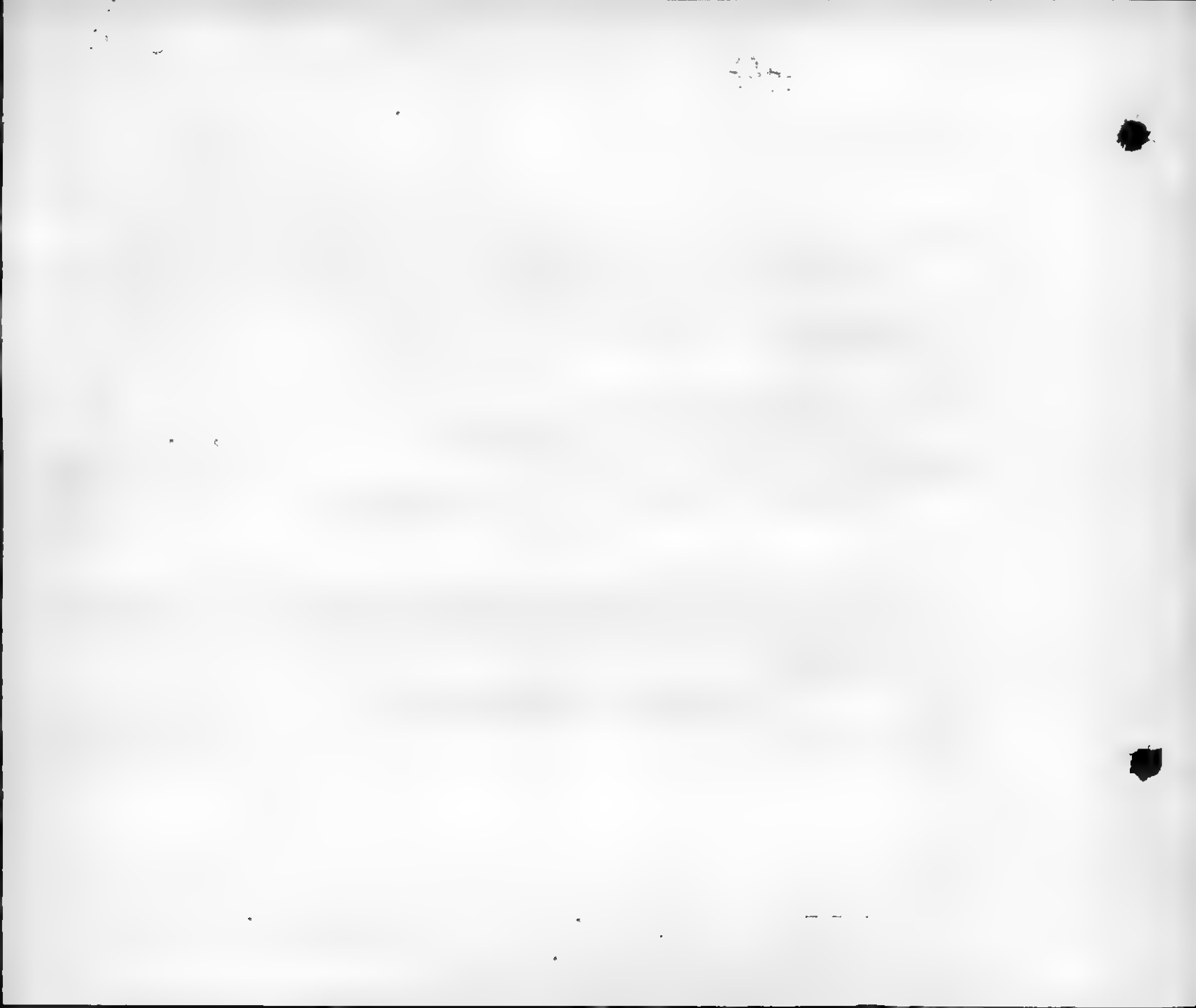
Reg. Dist. No.

05614

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CONSTANCE</b> Middle <b>ELIZABETH</b> Last <b>HUNT</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>19 58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Anderson Hunt</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Simpson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>George Burch</b>		Address <b>Waldorf, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> (c) <b>CORONARY THROMBOSIS (Jan-Mar. 1958)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b> <b>10 YEARS</b> <b>6 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>OCTOBER, 1947</b> to <b>MAY 30, 1958</b> , that I last saw the deceased alive on <b>MAY 30, 1958</b> , and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Gifford</b>		ADDRESS (Street, city or town, state) <b>Box #65, HUGHESVILLE, MD</b>	
PHYSICIAN'S NAME (Type) <b>John H. Gifford</b>		DATE SIGNED <b>6/1/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-2-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hunt Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Allesina</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



05615

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>My mom's house - LaPlata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>R.F.D. # 1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>BABY BOY KECKLER</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>31</i> Year <i>1958</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W.</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 31, 1958</i>	
9. AGE (In years last birthday) <i>12 1/2 yrs</i>		IF UNDER 1 YEAR Months <i>12</i> Days <i>29</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY <i>MD &amp; C</i>	
13. FATHER'S NAME <i>John Rollin Keckler</i>		14. MOTHER'S MAIDEN NAME <i>Wilma D. Morgan Dancy</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John R. Keckler Newburg Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Insufficient Oxygenation of blood</i> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Aspiration of meconium &amp; amniotic fluid</i> DUE TO (c) <i>12 hours</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-31</i> , 19 <i>58</i> , to <i>5-31</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-31-58</i> , 19 <i>58</i> , and that death occurred at <i>1:45 P.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED <i>V.B. DETTOR, M.D. LA PLATA, MD. 5-31-58</i>	
ACTUAL SIGNATURE <i>V.B. DETTOR, M.D.</i>		PHYSICIAN'S NAME (Type) <i>V.B. DETTOR, M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>buried</i>		22b. DATE THEREOF <i>6-3-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>md Real</i>		22d. LOCATION (City, town, or county) (State) <i>LaPlata md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archard Inc LaPlata md</i>		ADDRESS <i>LaPlata md</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. S. ...</i>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

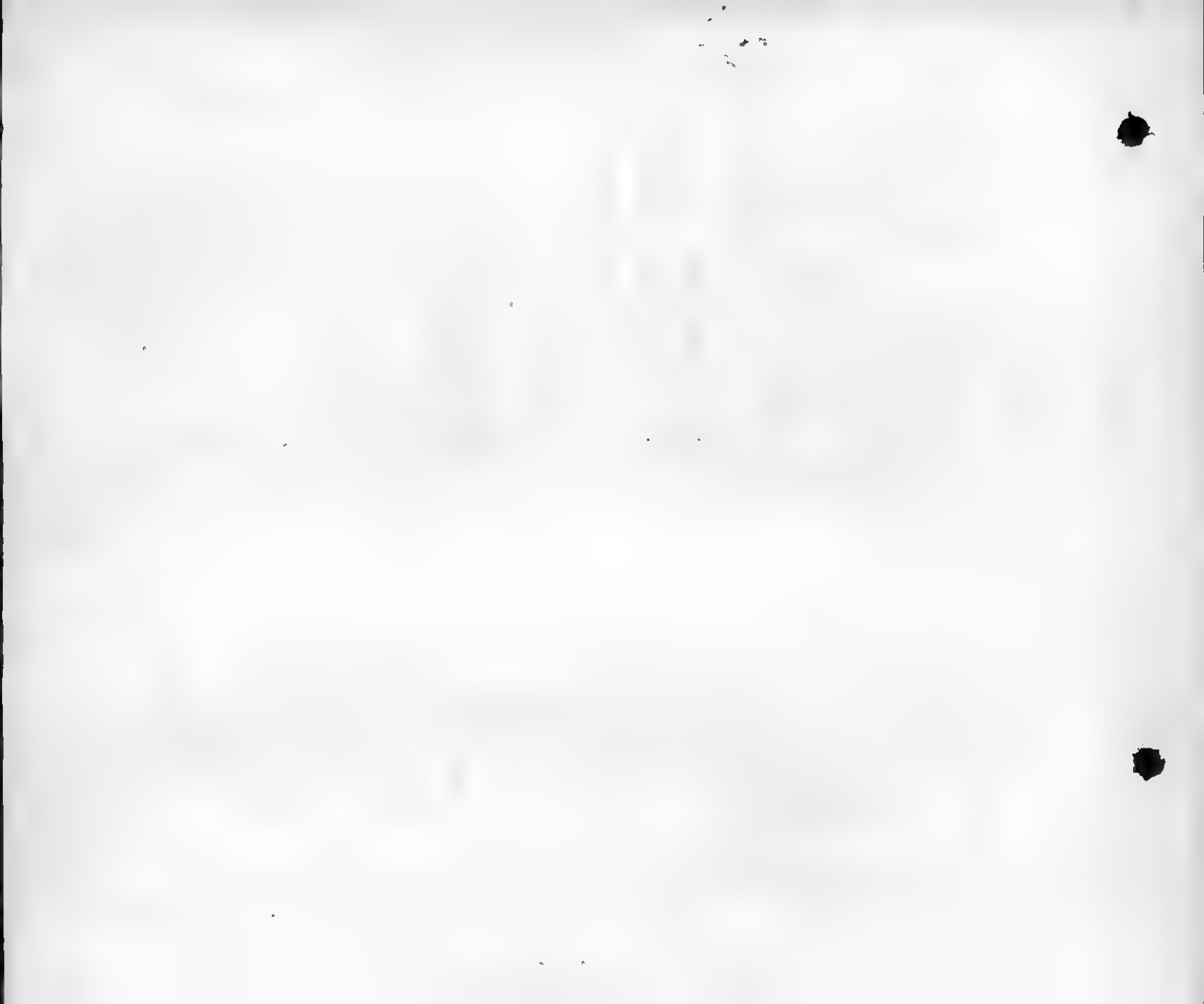
5625 CERTIFICATE OF DEATH

05616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>St Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakley</b>	
c. LENGTH OF STAY IN 1b <b>9 months</b>		18 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>CLARENCE THOMAS NEALE</b>		4. DATE OF DEATH <b>May 28 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1909</b>
9. AGE (In years last birthday) <b>48</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence Neal</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-0009</b>	
17. INFORMANT <b>Nellie Neal</b>		Address <b>LaPlata, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatosis of Bone</b> 144.2 DUE TO <b>Primary site uncertain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown</b> DUE TO (c) <b>unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mo. 3</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-23-58</b> , 19 <b>58</b> , to <b>5-28-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-27-58</b> , 19 <b>58</b> , and that death occurred at <b>2:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V. B. Dettor</b>		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b>	
PHYSICIAN'S NAME (Type) <b>V. B. DETTOR</b>		DATE SIGNED <b>5/28/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/31/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	22d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Clarke</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



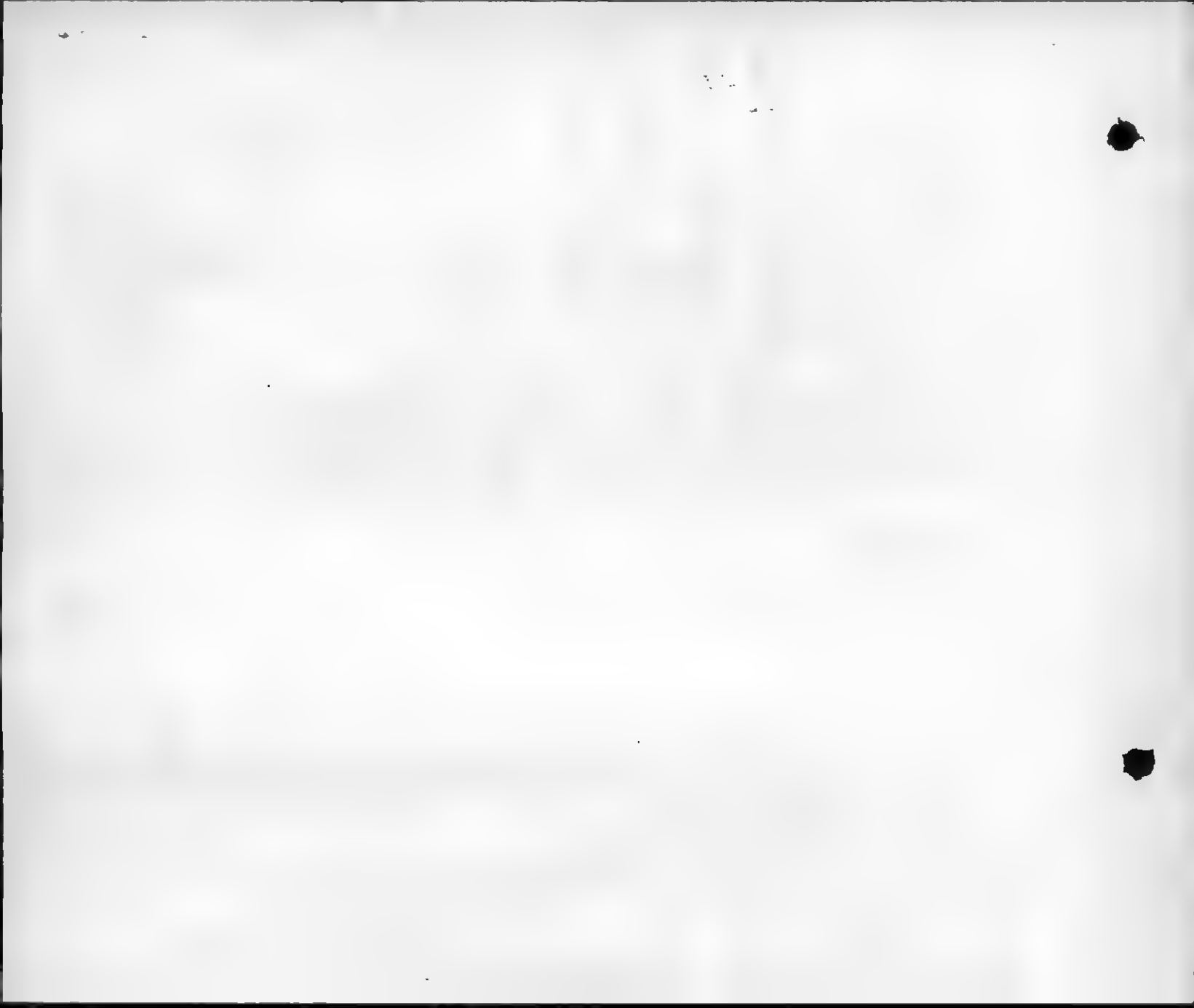
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5626 CERTIFICATE OF DEATH

Reg. Dist. No. 05617

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial</b>				d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Bessie</b> First <b>Parker</b> Middle <b>SHOTWELL</b> Last				4. DATE OF DEATH <b>May 20</b> Month <b>May</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W-S-W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 May 1903</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min <b>3</b>	IF UNDER 24 HRS. Hours <b>3</b> Min <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Parker</b>				14. MOTHER'S MAIDEN NAME <b>UNIK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>		17. INFORMANT <b>Killis F. Shotwell, Waldorf, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Collapse.</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-renal failure.</b> DUE TO <b>CUA</b> (c) <b>CUA</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>2 hrs.</b> <b>6 mins</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 May, 1958</b> , to <b>20 May, 1958</b> , that I last saw the deceased alive on <b>19 May, 1958</b> , and that death occurred at <b>2:10 A.M.</b> , from the causes and on the date stated above ACTUAL SIGNATURE <b>A. Wooddy</b> ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>20 May 58</b> PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODDY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedarville</b>		22d. LOCATION (City, town, or county) (State) <b>Cedarville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>MAY 23 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>	
c. LENGTH OF STAY IN 1b <b>55 yrs.</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>302 Strauss Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>302 Strauss Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Victoria</b> Last <b>Swann</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1897</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Chas. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Penny</b>		14. MOTHER'S MAIDEN NAME <b>Mary (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Cecil B. Swann</b>		Address <b>Indian Head, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>            400.1 DUE TO <b>Hypertensive Heart Disease</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____            (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pernicious Anemia</b></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b> <b>10 yrs</b></p> </div> </div>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank A. Swann</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank A. Swann M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Charles</b>		22d. LOCATION (City, town, or county) (State) <b>Glymont, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The HUNTT Funeral Home, Waldorf, Md</b>		24a. REC'D BY REGISTRAR <b>MAY 15 1958</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





5528

## CERTIFICATE OF DEATH

05619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Charles.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x LAPLATA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN HATHWAY TAYLOR</b>		4. DATE OF DEATH <b>MAY 11 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>US-W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 July 1899</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JOHN SAMUEL TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>Emily Hoover</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes.</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Son: John Hathway Taylor</b>		Address <b>La Plata, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery atherosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>1 day.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1949</b> , to <b>May 1958</b> , that I last saw the deceased alive on <b>10 May 1958</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur O. Woody</b>		ADDRESS (Street, city or town, state) <b>La Plata, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		DATE SIGNED <b>11 May 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rest</b>	22d. LOCATION (City, town, or county) (State) <b>La Plata, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 15 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. Brown</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for handwritten entry, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

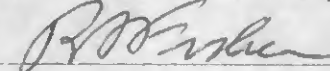


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07917

Reg. Dist. No.

5629

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Unknown</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Arehart Funeral Home</b>			d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>UNKNOWN</b>			4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.
				IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <b>Newborn</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hematoma probably due to birth trauma</b>  <b>760.0</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b>Unknown</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Unknown</b> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>		20f. (City or town) (County) (State) <b>Unknown</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/9/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. City Morgue</b>	
22d. LOCATION (City, town, or county) (State) <b>700 Fleet St., Balto., Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 21 '58</b>		24b. REGISTRAR'S SIGNATURE 	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS <b>700 Fleet Street</b>			

9VVVVVVV XVV

CREMATED MORGUE 7-18-58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0552

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: John Doe

AGE: 45

SEX: Male

RACE: White

DATE OF DEATH: 10/15/1915

PLACE OF DEATH: Home

Cause of Death: Heart Disease

Signature: [Signature]